

OUT-OF-STATE PROVIDERS

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenen provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the [provider enrollment chart](#) for additional details on enrollment eligibility and supporting documentation requirement.

South Dakota Medicaid has a streamlined enrollment process for ordering, referring, and attending physicians that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Out-of-state providers who are not enrolled as a South Dakota Medicaid provider must follow the process to obtain prior authorization beginning with the submission of a Prior Authorization Request Form. If the request is approved, the provider will receive written notification stating the determination was made pending enrollment. Once the approved service(s) have been provided, the provider must complete a new online enrollment and attach the resulting claim, written prior authorization approval notification, and other required documentation to become an enrolled provider.

All providers rendering services outside the boundaries of South Dakota are also required to submit a claim for services rendered that meets the timely filing requirements outlined in Reimbursement and Claims Instructions section of this manual with their enrollment paperwork. Provider services may also be subject to prior authorization requirements that will require either a prior authorization number to be included on the claim (for enrolled providers) or inclusion of the prior authorization approval pending enrollment notice (for providers not yet enrolled).

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's [online portal](#).

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Medicaid – Pregnancy Related Postpartum Care Only (47)	Coverage restricted to family planning and postpartum care only.

Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to co-payments and deductibles on Medicare A and B covered services.
Medicaid – Pregnancy Related Coverage Only (77)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to \$5,000 (80)	Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments.

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the hospital stay or service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Prior Authorization Required

South Dakota Medicaid requires a prior authorization for most services that are provided outside of South Dakota to improve health outcomes and efficiently utilize South Dakota Medicaid and CHIP resources. Prior authorization of out-of-state services helps ensure all in-state alternatives are considered and that seeking treatment for out-of-state care is medically necessary. The referring provider must submit a prior authorization request and medical records supporting the need for out-of-state care along with documentation of care already provided in state to South Dakota Medicaid.

Exceptions to the prior authorization requirement are the following:

- Services provided within 50 miles of the South Dakota border or services provided in Bismarck, North Dakota. This exception does not apply to nursing facilities.
- Medicare is the primary payer;

- Lab, radiology, pathology, durable medical equipment, and pharmacy services do not require additional prior authorization unless the service or item is prior authorized for in-state providers; and
- Service provided to children in DSS foster care custody.

Prior Authorization Process

A prior authorization determination may take up to 30 days for an elective service. These will be completed in the order they are received. Recipients should not schedule travel until an authorization has been approved by South Dakota Medicaid.

A [Prior Authorization Request Form](#) must be submitted along with additional information supporting the need for out-of-state services. The form can be submitted by the provider where services will be provided or by the recipient's primary or specialty care provider in advance of an anticipated out-of-state service.

The referring provider must also verify that there is no provider in South Dakota, or closer to South Dakota, who can provide the service. A written notification of approval or denial will be sent to the contact provided as soon as a determination is made.

New referrals out-of-state

- Recipients must have a current (within at least 6 months) like specialist evaluation in South Dakota when that specialty is available in South Dakota.
- If there have been specific physician recommendations for treatment by an in-state physician, those prescribed treatments must be completed with documentation of the results submitted to determine if those efforts have been effective or if additional needs still exist.
- The referral must be supported by medical necessity, which means that the in-state specialist documents a concern or is unable to meet those recipient's specific medical needs. Referrals based solely on patient requests or without documentation of why needs cannot be met in South Dakota, will not be approved.
- Second opinions must be provided in South Dakota when there is another option for the desired specialty available. If there are specialists in South Dakota, documentation must demonstrate that the out-of-state specialist has additional training, certification, or testing not available in South Dakota.
- Referrals to out-of-state tertiary care centers and specific diagnosis-based clinics will be reviewed to determine if the requested services are available in South Dakota. If the necessary specialists, testing, and treatment are available in South Dakota, even if it is not promoted as a tertiary care center or diagnosis-based clinic, that care must be utilized and exhausted first. The transfer of medical records is expected when multiple specialists, testing, or treatment is not all located in the same clinic to ensure adequate coordination of that multidisciplinary care in South Dakota.
- Letters are not a substitute for medical records.

Emergencies and Transfers

If an inpatient hospitalization admission is the result of an emergent or urgent situation, or is a transfer situation, the [Prior Authorization Request Form](#) should be submitted within 48 hours and authorizations will be expedited and completed within 2 business days of the request. No prior authorization is needed for the transportation. Please refer to the [transportation manuals](#) for those coverage policies.

Established Care

If a recipient is already established with an out-of-state provider, medical records will be reviewed to examine the need for continued care with the out-of-state provider. Prior Authorization will be granted when there is a medical need for continued services with the out-of-state provider. Care is considered established when a recipient has been seen by the requested out-of-state specialist within the previous 12 months.

When the condition being treated has been determined to be stable and the same specialty is available in South Dakota, routine follow-up will not continue to be covered out-of-state. A transition letter will be mailed to the recipient or guardian, as well as the provider to explain next steps. One additional visit may be approved to allow the patient and provider to discuss referral options or send any questions or concerns to South Dakota Medicaid.

Physician and Other Licensed Practitioner Services

Only one prior authorization is needed for a hospital stay. Physician and other licensed practitioner services are included as part of the prior authorization for the inpatient stay. A prior authorization will be issued to the prior authorization contact for the inpatient facility for the dates of the approved hospital stay. In addition to the hospital facility, this authorization must be shared with all physicians to use for visits billed during that hospital stay.

When Services are Denied

- Requests that are denied always include an explanation of the reason for denial, as well as instructions for recipients to exercise the right to appeal within 30 days of the date of the letter if desired.
- Providers may make a second prior authorization request with new medical records or documentation. Any time new requests and records are submitted, South Dakota Medicaid will consider the new records to make a new prior authorization determination.

When Services are Approved

- Providers must send all related medical records and workup to the out-of-state provider to ensure efficient use of out-of-state services and to prevent duplication of services.
- Medical records from the out-of-state services should also return to the South Dakota specialist and primary care provider for continuity of care as appropriate.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

Prior Authorization

Inpatient Services

Effective January 13, 2014 South Dakota Medicaid implemented a Prior Authorization requirement on all inpatient hospitalizations more than 50 miles outside of the state of South Dakota, except Bismarck, North Dakota.

Outpatient Services

Effective September 1, 2014 South Dakota Medicaid will expand the Out-of-State Prior Authorization requirement to most medical services received more than 50 miles outside of the state of South Dakota, except Bismarck, North Dakota. This applies to all Medicaid recipients, except those in foster care.

Prior Authorization by South Dakota Medicaid does not guarantee payment. The provider must be an enrolled South Dakota Medicaid provider and must submit a timely and accurate claim. Also, the recipient must be eligible for coverage on the date of service.

Out-of-state providers not currently enrolled in South Dakota Medicaid must obtain prior authorization and provide the service before provider enrollment can be completed. See [FAQs](#) for additional information.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Reimbursement

Professional Services

Physicians and other licensed practitioners are reimbursed according to the applicable fee schedules on our [website](#). Out-of-state inpatient hospitals are reimbursed on the same basis as the Medicaid agencies in the state where the hospital is located.

Inpatient Hospitals

South Dakota Medicaid reimburses out-of-state inpatient hospital's on the same basis as the Medicaid agency in the state where the hospital is located. If the home state refuses to provide the amount they would pay for a given claim, the payment will be at 44.15 percent of the provider's usual and customary charge. Payment is for individual discharge or transfer claims only. Out-of-state specialty hospitals are reimbursed at 44.15 percent of the provider's usual and customary charge unless otherwise approved by the state. There is no annual cost settlement with out-of-state hospitals or in-state DRG hospitals unless an amount is due the South Dakota Medicaid program.

Outpatient Hospitals

Outpatient laboratory services will pay at the [Laboratory Services fee schedule](#) rate. Outpatient surgical procedures will be reimbursed at the rate listed in the [Specialized Surgical Hospital fee schedule](#). For all other outpatient services, the reimbursement rate is 38.20 percent of the hospital's usual and customary charge.

Nursing Facilities

All out-of-state nursing facility placements must be prior authorized by the Department of Human Services, Division of Long-Term Services and Supports, and will only be approved when documentation supports that an individual's needs cannot be met in South Dakota. These facilities are excluded from the 50-mile radius of the South Dakota border exception.

The reimbursement rate for out-of-state facilities providing nursing services to residents of the State of South Dakota is the lesser of the Medicaid rate established by the state in which the facilities are located or the South Dakota statewide average Medicaid rate for all in-state facilities. Payment to out-of-state facilities for care not available at in-state facilities is at the rate recognized for the facility by the Medicaid agency in the state in which the facility is located.

Claim Instructions

Professional Services

Physicians and other licensed practitioners should bill using the CMS 1500 claim form or 837P electronic transaction. Detailed claim instructions are available on our [website](#).

Facilities

Facilities should bill using a UB-04 claim form or 837I electronic transaction. Detailed claim instructions are available on our [website](#).

REFERENCES

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- [Administrative Rule of South Dakota \(ARSD\)](#)
 - [South Dakota Medicaid State Plan](#)

- [Code of Federal Regulations](#)

QUICK ANSWERS

- 1. Do providers that are within 50 miles of the South Dakota border need to submit a claim with their enrollment application?**

Yes, although prior authorization is not required a claim still must be submitted with the application.

- 2. Why do most out-of-state service require a prior authorization requirement being implemented?**

In order to improve health outcomes and efficiently utilize South Dakota Medicaid and CHIP resources, care should be provided in, or as close to South Dakota as possible. Prior authorization of out-of-state services helps ensure all alternatives are considered and that seeking treatment out-of-state care is medically necessary.

- 3. What if I am not an enrolled South Dakota Medicaid Provider?**

Out-of- state providers who are not enrolled as a South Dakota Medicaid provider must obtain prior authorization and provide the approved service(s) prior to enrolling in South Dakota Medicaid. These providers should submit the Prior Authorization Request Form. If the request is approved, the provider will receive written notification stating the determination was made pending enrollment. The provider must submit the resulting claim and the written prior authorization approval notification with the Provider Enrollment documentation.

Please note that [ARSD 67:16:35:04](#) requires claims to be filed within 6 months of the date of service.

- 4. How are prior authorization determinations made?**

Registered nurses review each request for medical necessity criteria. All covered services must be medically necessary per [ARSD 67:16:01:06.02](#).

To ensure that the out-of-state service is the most conservative option to meet the recipient's needs, the registered nurse will also verify that the service is going to be provided at the closest possible location.

Registered nurse reviewers may also consult the South Dakota Medicaid Medical Director to assist in complex determinations.

- 5. Who is responsible for obtaining the out-of-state prior authorization?**

The referring provider is expected to initiate the out-of-state prior authorization request and provide supporting documentation. This responsibility should not be delegated to the recipient. When referring a Medicaid recipient to services out-of-state, the prior authorization request form

should be submitted upon referral and must include an explanation of the need for care out-of-state.

6. What form should providers use?

Services requiring prior authorization are listed on the [prior authorization webpage](#). Providers should use the form associated with the type of service they are seeking prior authorization for. If the service only requires prior authorization because it is being done out-of-state, the Out-of-State Prior Authorization Request form should be utilized.

7. What if a recipient is already established with an Out-of-State provider?

Medical Records will be reviewed to examine the need for continued care with the out-of-state provider. Prior Authorization will be granted when there is a medical need for continued services with the out-of-state provider.

When the condition being treated has been determined to be stable and the same specialty is available in South Dakota, routine follow-up will not continue to be covered out-of-state. A transition letter will be mailed to the recipient or guardian, as well as the provider to explain the next steps. One additional visit may be approved to allow the patient and doctor to discuss referral options or send any questions or concerns to South Dakota Medicaid.

8. What if a patient already has a service scheduled?

Submit the [Prior Authorization Request Form](#) and supporting medical records as soon as possible to allow South Dakota Medicaid time to review the situation and issue a determination prior to the scheduled service. Recipients should not schedule travel until an authorization has been approved by South Dakota Medicaid.

9. Are emergencies exempt from out-of-state prior authorizations?

Yes. There is no need for prior authorization for true emergency services. Services must be billed indicating this emergency status in order to be exempt. Once a condition is stabilized, an authorization will be needed for reimbursement of any further services after the emergent care. Retro authorizations can be requested if any services provided will not be billed as an emergency service.

10. What process should providers follow for emergency inpatient admissions or urgent situations during holidays or weekends?

If the inpatient hospitalization is the result of an emergency, the prior authorization may be granted retroactively.

In the case of inpatient hospitalizations, hospitals must submit the Prior Authorization Request Form to South Dakota Medicaid within 48 hours and an expedited determination on these cases

will be made within two business days. Providers should also expect to provide at least weekly updates on hospitalizations to South Dakota Medicaid after notification.

11. How are physician and other professional services covered during an inpatient stay?

Only one prior authorization is needed for the hospital stay. Physician services are included as part of the prior authorization for the inpatient stay. A prior authorization will be issued to the prior authorization contact for the inpatient facility for the dates of the approved hospital stay. In addition to the hospital facility, this authorization must be shared with all physicians to use for visits billed during that hospital stay.

12. What if the recipient has other private health insurance (PHI)?

If the patient has other private health insurance, please follow the requirements of the primary insurance in addition to seeking South Dakota Medicaid approval as the secondary payer. Prior authorization from South Dakota Medicaid is required for the recipient to receive assistance with transportation, food, and lodging reimbursement even if there is no need for South Dakota Medicaid to reimburse the medical service.

13. What if the recipient has Medicare?

If the patient has Medicare in addition to South Dakota Medicaid, please follow the Medicare requirements, as South Dakota Medicaid's payments are contingent upon Medicare's determination.

[Non-Emergency Medical Transportation \(NEMT\)](#) requires prior authorization for the recipient to receive assistance with travel, food, and lodging reimbursement out-of-state even if there is no need for South Dakota Medicaid to reimburse the medical service.

14. Does the prior authorization requirement apply to children in DSS custody?

No, children in DSS custody are exempt from this requirement.

15. How long will it take to obtain a prior authorization?

A prior authorization determination may take up to 30 days for an elective service. These will be completed in the order they are received. Recipients should not schedule travel until an authorization has been approved by SD Medicaid.

If an inpatient hospitalization admission is the result of an emergent or urgent situation, or is a transfer situation, the [Prior Authorization Request Form](#) should be submitted within 48 hours and authorizations will be expedited and completed within 2 business days of the request.